

## COMMONWEALTH PHYSICIANS FOR WOMEN, PC

### Patient Information

First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_ Marital Status: Single Married Divorced Widowed

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_

Spouse / Parent  Name \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Referring Physician \_\_\_\_\_

### Insurance Information

Primary Insurance \_\_\_\_\_ ID/Group No. \_\_\_\_\_

Policy Holder \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship: Self Spouse Parent Other

Policy Holder's Employer/Address \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ ID/Group No. \_\_\_\_\_

Policy Holder \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship: Self Spouse Parent Other

Policy Holder's Employer/Address \_\_\_\_\_

I hereby authorize Commonwealth Physicians for Women, PC to release the information requested to the insurance company named hereon. I hereby assign payment directly to Commonwealth Physicians for Women, PC otherwise payable to me. I understand that I am responsible for supplying the necessary information to obtain full benefits from my insurance. Failure to do so will result in all charges incurred being my responsibility and payment in full is required on the date of services. As the insured, I am to obtain necessary authorization and referrals for the services requested. I understand that I am financially responsible for charges (including laboratory fees) not covered by this authorization. I agree that in the event my account must be turned over to an attorney for collection, I will be responsible for attorney's fees and court cost.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient or Parent of Minor

I give permission for CPW personnel to leave a detailed message on my telephone answering service at:

Home Work Cell None

Signature: \_\_\_\_\_ Date: \_\_\_\_\_